# Family ties

**Richard Goldbloom, OC, MD**

The articles that follow link 3 generations of physicians from the same family. Pediatrician Richard Goldbloom, the "middleman," ties together the addresses that his father Alton and his own son David gave almost 30 years apart to graduating medical students at different universities. Even though one of the speakers graduated in 1916 and the other in 1981, Richard Goldbloom reports that their speeches are linked by common themes that prove that medicine is, indeed, a timeless profession.

Rereading my father's address to McGill's 1966 graduating class and my son David's lecture to his counterparts at the University of Toronto in 1995 fills me with warm memories, pride and a great sense of continuity.

My father possessed a keen sense of history and of what was to come, qualities that his grandson obviously inherited. Before even considering a career in medicine, he worked as a professional actor. His stage experience undoubtedly enhanced his widely acclaimed skills as a teacher and communicator. He was remarkably well read and quoted liberally from Shakespeare and other authors of classic poetry and literature.

Although he is best remembered as a teacher and clinician, my father was no stranger to scientific research, especially early in his medical career. In the 1930s he collaborated with a young colleague, Maurice Brodie, in experiments involving the use of convalescent serum to induce passive immunity to poliomyelitis in rhesus monkeys. At one point my brother and I, still young schoolboys, were whisked off to New York's Rockefeller Institute as reluctant volunteers — informed consent had not yet been invented — to receive large, painful intramuscular injections of the stuff.

Although we never got polio, these attempts at passive immunization were never highly successful. Reporting on his work to the American Pediatric Society, my father predicted that the conquest of polio would occur only if and when the virus could be propagated successfully in the laboratory. Some 20 years later, when I arrived as a green pediatric resident at the Children's Hospital in Boston, my first ward attending physician was Fred Robbins, who had just been named corecipient of the Nobel Prize for the then extraordinary achievement of growing polio virus in tissue culture. He was well aware of my father's early attempts at immunization and of his prophecy, and reminded me of his prescience.

In his address to McGill's Class of '66, my father marvelled at the medical miracles he had witnessed. I recall one of them vividly. During my childhood there were many anxious discussions around our dinner table about one of my father's patients. This 10-year-old girl had been desperately ill for weeks with persistent high fever and recurrent suppurative foci that required surgical drainage. She had lost an enormous amount of weight and it seemed certain she would die. Then my father and my uncle Harry Ballon, a surgeon who had performed the drainage procedure, received word of a new German drug that appeared to have antibacterial qualities. The drug, Prontosil, was an ancestor of the sulfonamides. Somehow they managed to acquire a small supply and administer it, and within 48 hours the youngster became afebrile, began to eat and progressed rapidly to a full recovery. My father's excitement about that miracle remains a vivid memory.

David's lecture themes are also timely and timeless. Clearly, he too was inspired by my father, and in his speech he quoted liberally his grandfather's views on the

*Experience*

*Expérience*

**The late Alton Goldbloom, a McGill graduate who spent his medical career in Montreal, first wrote for *CMAJ* in 1917. His son, Pediatrician and Dalhousie University Professor Emeritus Richard Goldbloom, also graduated from McGill, and he continued the writing tradition begun by his father. The latest Goldbloom to take up the torch as physician–contributor to *CMAJ* is Richard's son David, a Professor of Psychiatry at the University of Toronto and Physician-in-Chief at the Centre for Addiction and Mental Health, which was formed from the recent merger of the Clarke Institute of Psychiatry, Addiction Research Foundation, Queen Street Mental Health Centre and Donwood Institute. And yes, he too graduated from McGill.**

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**Dr. Richard Goldbloom: a proud past**

physician's responsibility to treat illness as well as disease. David reminded the Class of '95 that their relationship with patients should transcend the advances of science. His warning against co-opting patients as political allies in our disputes with the people who run the health care system is as timely as tomorrow. Sadly, too many professional organizations and individual physicians have abused the doctor–patient relationship in exactly that way.

I have been the fortunate beneficiary of innumerable past and present sources of family pride. These include finding myself in the middle position among 3 generations (so far) of Canadian pediatricians — my elder son, Alan, is the latest in that particular line of succession. With my younger son, David, I am in the midst of 3 generations of contributors to *CMAJ* over the last 81 years.

Most of all, I derive great pride from the wit and wisdom that has emanated from both extremes of our little familial strand of DNA. It is a privilege to be the middleman in such a sequence. ?

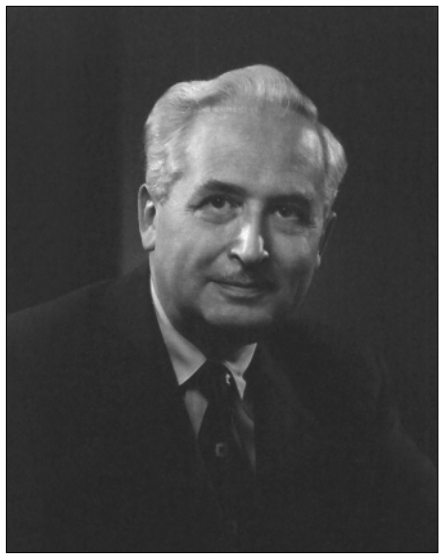
## A message to the Class of '66

**Alton Goldbloom, MD**

*The following are edited excerpts from Dr. Alton Goldbloom's address to the Class of '66, McGill University medical school.*

The Class of '16 heartily greets and congratulates the Class of '66 — a full half century apart. We greet you with an *ave atque vale* [hail and farewell], with a glance backwards at what we were, at what we knew and what we were taught 50 years ago, and with a long look at the days to come. . . .

Our days in medical school were chiefly characterized by empiricism and didacticism. Physicians and surgeons were of necessity obliged to rely on their instincts, their limited knowledge and their judgement. When we began to study medicine it was little more than a decade since Ross's discovery of the parasite of malaria, the arsenicals had not yet replaced mercury in the treatment of syphilis, bacteriology was in its early adolescence and chemotherapy was a mewling infant. We were taught that with mercury, opium and salicylates, one could practise effectively if no other drugs were available.



**Dr. Alton Goldbloom: time marches on**

The list of diseases for which "expectant treatment" was the only treatment was formidable. When at the final examination we were asked how to treat, say, pneumonia, the perfect answer was always the same — "initial purgation, rest in bed, fresh air, plenty of fluids and treatment of complications as they arise." That always earned 100%.

Didacticism reached its apex during examinations. We learned that one must never give the examiner an answer, however original, which he did not expect. We learned from senior students and recent graduates who might ask what — and what answer to give to whom. We all wallowed in a morass of mutual ignorance, but it was only the student who was permitted to admit it. The physician and particularly the surgeon, and, heaven help us, the specialist — they must for their own self-esteem be positive. Not that we did not have inspiring teachers — we had Charles Martin, we had John McCrae, we had Harold Cushing, we had W.F. Hamilton, and they were outstanding — but medicine was in its infancy and only these few visualized its potential. X-rays were first discovered in 1895, and by 1911 they were still in limited use. Ponderous glass plates showed us fractures and empyemas. . . . The electrocardiogram was done in a dark room — half of it occupied by the apparatus itself, with the patient seated in a chair, his arms and legs emersed in buckets of salt solution. The rectangular glass slide was developed and then printed on photographic paper. . . .

Pneumonia and erysipelas were self-limited diseases, amenable to expectant treatment. I imagine "expectant" meant that you expected that the patient would either recover or die. We battled hopelessly with diabetes, scarlet fever and rheumatic carditis, and often, though not always, with diphtheria. . . .

It was with the discovery of insulin that endocrinology got its greatest fillip. We became interested not only in blood sugar but also in homeostasis, and not only in nitrogen balance but also in mineral metabolism as affected by vitamins, endocrines, age and so forth.

In his early research on rickets one of my classmates, Harry Goldblatt, was the first to separate vitamin A from vitamin D and to show that they were 2 separate vitamins. He also, without realizing it, virtually stumbled on irradiation of sterols in the production of vitamin D. Another classmate, the late Louis Gross, published his book on the circulation of the heart at age 24. It remains a classic. . . . [He] conceived the idea of infusing the heart with radio-opaque substances then taking x-ray photographs. . . .

In our day genetics consisted of a single lecture on Mendelian inheritance and a little bit about human chromosomes. Metabolic diseases were known but few were understood. Storage diseases were unknown as such and the word thesaurismosis had yet to be coined. Glucose was directly absorbed from the intestine without the agency of any enzyme system and converted into glycogen in the liver. Enzymes were talked about but chiefly in relation to digestion within the intestine.

No wonder we were empirical and didactic. In those days I often wondered if we were not more eager to have been proven right at the postmortem table because we were so often wrong and ineffective at the bedside. . . .

Of the present state of medicine, you new graduates can speak with greater knowledge and authority than we can. The past generation has [witnessed] the conquest of many bacterial diseases. We now face an era in which viral diseases will be conquered. This is your era and from you . . . may come the great breakthrough that we all eagerly await.

So, the Class of 1916 greets the Class of 1966 with congratulations, with hopes for your future, with an *ave atque vale* and, alas, with a *morituri te salutamus*: we who are about to die salute thee.

# "You have been granted an extraordinary privilege"

**David S. Goldbloom, MD**

*The following are edited excerpts from Dr. David Goldbloom's address to the Class of '95, University of Toronto medical school.*

Ours is a highly conservative profession that frequently and morbidly predicts its own demise. Every evolution of our roles is inevitably labelled as "the end of medicine as we know it." Changes to reimbursement practices are a frequent undercurrent in perceived threats to the doctor–patient relationship. Such was the case when universal health insurance was introduced almost 30 years ago; more recently, as our society grappled with limited resources in the context of unlimited and competing needs, physicians were encouraged to politicize their patients through posters and pamphlets.

If you feel that "this political stuff" isn't why you went to medical school, then you should also assume that "this political stuff" isn't why your patient came to see you. Be careful about enlisting your patients in your profession's battles. You are there to serve their needs, not vice versa.

There is no question that the professional roles of physicians continue to be transformed. Indeed, there are only 2 things you can count on: further change is inevitable and the rate of change is going to increase. . . . The explosion in technology and information and the advances in therapeutics, as well as the ethical dilemmas they pose, will be viewed as quaint by medicine's next generation, but your relationship with your patients transcends these changes. As was the case 100 years ago, your patients look to you for the provision of hope and the reduction of suffering. If you lose sight of this as you fractionate their serum amylase or try to interpret their SPECT scan, you will have lost the essence of what it is to be a doctor.

The reality is that your role has many components. Recently an organization, Educating Future Physicians for Ontario, spelled out these different roles: medical expert/clinical decision-maker; health advocate; gatekeeper; collaborator; communicator; scholar; and professional person.

These roles are hardly new but they reflect the priorities and vocabulary of our times. It has also been written: "Now, more than ever, must the physician be regarded as the guide of those under his charge — not only a guide during illness, but a guide in health as well. The advice of the physician is now sought in matters quite far removed from problems in diagnosis and therapeutics, where a knowledge of physiology,

**Dr. David Goldbloom: much has changed, but much has not**

pathology and anatomy help but little in the solving of his problems. He is not only called upon to relieve physical distress but he often plays an important part in helping to solve many complex problems of human relationship. The well-beloved, useful family physician, now fast disappearing, understood perhaps more than others how far afield from the narrow paths of the medical curriculum his daily contact with human beings took him. His were frequently problems whose solution depended not at all upon a knowledge of medicine in its strictest sense, but rather upon a wide and broadly sympathetic acquaintance with human nature, and upon the practical application of principles learned long after his graduation from the medical school."

These words appeared in the *New York State Journal of Medicine* in 1928. They were written by my grandfather, Dr. Alton Goldbloom. . . .

So much for the art of being a doctor — what of the science? One epidemiologist has said that, based on current rates of biomedical publication, a physician who reads an article a day will be 55 centuries behind at the end of a year. . . . Your greatest scientific skill will be your approach to the selective acquisition of new knowledge and its integration into your daily work. Computer literacy is not enough. Skills of critical appraisal are as necessary for the clinician as for the researcher, and they are the foundation for evidence-based care. At its best, evidence-based medicine means that neither a knowledge of pathophysiology nor an experience of what worked the last time you confronted this problem is enough.

Your class represents a watershed in the history of the Faculty of Medicine at the University of Toronto: it is the last class to complete a curriculum based largely on the travels of Abraham Flexner to 155 medical schools in Canada and the US in 1909; based on those visits, he advocated a model for medical education that largely went unchallenged until 30 years ago, when McMaster University set up its innovative medical school. When this was repackaged in Massachusetts years later as the Harvard New Pathway, it suddenly became palatable to the powers that be in Toronto!

It is easy to take potshots at the old curriculum, but in the final analysis what counts is not the protocol but the protoplasm. My grandfather, in his 1959 autobiography, reminisced about his . . . first clinical teacher, John McCrae. McCrae was "a man of great dignity and great culture whose bedside clinics in physical diagnosis were interspersed with classical quotations and whose English had a poetic cadence. . . . We knew that he wrote poetry but we did not bother to find out what kind of poetry, not until the war, not until we read *In Flanders Fields* and John McCrae was dead. Our contact with him was short and never intimate but brief as it was, it was impressive. To me he imparted a feeling for the human side of medicine. Aloofness, excessive dignity, superiority and frock coats were the common defences for the medical ignorance of some of his colleagues; with McCrae it was humility and compassion. I learned from him, once and for all, that medicine was something more than merely knowing the signs, symptoms and treatment of disease and that these people, human beings, showed signs and symptoms. The patient as a person was not a self-evident concept in 1913 as it is today when, thanks to the psychiatrists, it is an integral part of medical teaching."

I wish for each of you the opportunity in your training to spend time with a John McCrae who will inspire you, encourage you and ultimately shape you as you develop your professional identity. This aspect of apprenticeship and emulation transcends our territorial and political preoccupation with curriculum reform — it is indeed the triumph of protoplasm over protocol.

Try to ignore the voices of disillusion and pessimism as you start your adventures as physicians; while you confront problems that previous generations never even dreaded, you have opportunities that they never even dreamed of. You have been granted an extraordinary privilege to know people's suffering, to provide a beacon of hope and trust, and to improve the quality of people's lives — by preventing disease, by reversing it, or by the equally noble and more common task of helping people to adapt to it. For this privilege you are in debt — to your families who have supported you, to the university and the province that have made your education possible, and ultimately to your patients, whose benefits from your care are your greatest reward.